Referral Form - Center for Counseling and Wellness

Instructions: Referral form should be completed by referring worker/organization with input from the family. Please complete all fields. If unsure or not applicable, indicate on the form. Email completed referral forms to mgetty@fsnwpa.org

Date of Referral:	
Client Name:	**Social Security Number:**
Date of Birth:	**Gender:**
Address:	
Phone Number:	**Email Address:**

Parent/Guardian:	**Relationship to Client:**	
Home Phone Number:	**Can Contact?** ☐ Yes ☐ No	**Leave Message?** ☐ Yes ☐ No
Cell Phone Number:	**Can Contact?** ☐ Yes ☐ No	**Leave Message?** ☐ Yes ☐ No
Who has <u>legal</u> custody (medical decision-making)?		

Referral Source Name:	**Email Address:**
Reason for Referral:	
Current Concerns of Client/Family:	
Services requested:	☐ Outpatient Therapy ☐ Trauma-Focused Therapy ☐ Psychiatric Assessment
Barriers that would affect treatment (i.e. interpreter, transportation, childcare, internet connection):	

Is client currently receiving medication management? ☐ Yes ☐ No	
Medication(s):	
Prescriber:	
Are there currently any other service providers involved? ☐ Yes ☐ No	
Provider name and contact information:	
Current Diagnosis (if available):	**Diagnosed by:**
Insurance Provider:	

For internal referrals only		
Referring Program:	**Referring Employee:**	**Extension:**
Concerns/Reason for Referral:		